



New Jersey Office of the Attorney General

Division of Consumer Affairs

Board of Pharmacy

124 Halsey Street, 6th Floor, Newark, NJ 07102

(973) 504-6450

Joint Application to Conduct a Centralized Prescription Handling Pharmacy Service

Pharmacies that plan to engage in central prescription handling in accordance with N.J.A.C. 13:39-4.19 must submit this application to the Board of Pharmacy.

All of the pharmacies involved in the shared central handling must complete and jointly file this application. It must be filled in completely, sworn to and mailed to the Board of Pharmacy.

Please remember to include with this application a completed service agreement signed by all of the involved parties.

Please print clearly with ink.

Pursuant to N.J.A.C. 13:39-4.19, the following pharmacies and/or corporations hereby make application for approval to conduct centralized prescription handling and certify to the correctness of the following information:

1. _____
2. _____

☐ **Check box and attach a list if there are more than two pharmacies involved in this specific Central Prescription Handling application and provide all of the required information for each additional pharmacy.**

If participating pharmacies have different ownership - Complete Attachment "A" for each pharmacy that will be participating in the centralized prescription handling. (Make as many copies as you need.) Corporations with more than one pharmacy participating should submit documentation (a spreadsheet is preferred) that contains the following information: the name, address, telephone number, and the license numbers (state and D.E.A.) of each participating pharmacy, as well as the function(s) to be performed in the centralized prescription handling process.

If all participating pharmacies have a common owner - Complete one copy of Attachment "A" and submit documentation (a spreadsheet is preferred) that contains the following information: the name, address, telephone number, and the license numbers (state and D.E.A.) of each participating pharmacy, as well as the function(s) to be performed in the centralized prescription handling process (i.e. intake, central processing, central fill and dispensing).

You will be notified by mail when your application has been approved by the Board.

Attachment "A"

Application to Conduct a Centralized Prescription Handling Pharmacy Service

1. Complete the information below for **Pharmacy #1**:

- (a) Name of pharmacy: _____
- (b) Street address of pharmacy: _____
- (c) City: _____ State: _____ ZIP code: _____
- (d) Telephone number: _____
(include area code)
- (e) Home state pharmacy license number: _____
- (f) New Jersey Board of Pharmacy license number: _____
- (g) Federal controlled substance (D.E.A.) registration number: _____
- (h) Name of Registered Pharmacist-in-Charge: _____
- (i) Select the functions in the centralized prescription handling process that this participant will perform:
☐ Intake ☐ Central processing ☐ Central fill ☐ Dispensing
- (j) Are the licenses of all the pharmacists and pharmacy technicians (if applicable) in good standing in each state in which they are licensed? ☐ Yes ☐ No
- If "No," provide details:

2. Complete the information below for **Pharmacy #2**:

- (a) Name of pharmacy: _____
- (b) Street address of pharmacy: _____
- (c) City: _____ State: _____ ZIP code: _____
- (d) Telephone number: _____
(include area code)
- (e) Home state pharmacy license number: _____
- (f) New Jersey Board of Pharmacy license number: _____
- (g) Federal controlled substance (D.E.A.) registration number: _____
- (h) Name of Registered Pharmacist-in-Charge: _____
- (i) Select the functions in the centralized prescription handling process that this participant will perform:
☐ Intake ☐ Central processing ☐ Central fill ☐ Dispensing
- (j) Are the licenses of all the pharmacists and pharmacy technicians (if applicable) in good standing in each state in which they are licensed? ☐ Yes ☐ No
- If "No," provide details:

The affidavits on the next pages must be completed by the owner, or a partner, as listed on this application or, if the pharmacy is owned by a corporation, by a principal officer.

3. Have you attached a copy of the contractual agreement as per N.J.A.C. 13:39-4.19(d)1? ☐ Yes ☐ No

If "No," provide details:

Affidavit - Party #1

Must be sworn to before a notary public or other authorized officer.

I do solemnly swear or affirm that the answers and statements made in this form are true and correct to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny or withdraw approval to function as a participant in a Central Prescription Handling Pharmacy Service. I understand that I am responsible for ensuring that each pharmacist-in-charge of each pharmacy participating in the centralized prescription handling process has been notified and has acknowledged that he/she is responsible for complying with N.J.A.C. 13:39-4.19, and for conducting and managing the pharmacy so as to be in compliance with all applicable state and federal laws.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Name of Pharmacy (give exact legal title)

Title

Print name

Authorized signature

Subscribed and sworn to me this _____

day of _____, 20____

Name of Notary Public (please print)

Signature of Notary Public

Affix seal here

If more than two (2) parties are participating in this agreement, attach additional affidavits as needed.

Affidavit - Party #2

Must be sworn to before a notary public or other authorized officer.

I do solemnly swear or affirm that the answers and statements made in this form are true and correct to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny or withdraw approval to function as a participant in a Central Prescription Handling Pharmacy Service. I understand that I am responsible for ensuring that each pharmacist-in-charge of each pharmacy participating in the centralized prescription handling process has been notified and has acknowledged that he/she is responsible for complying with N.J.A.C. 13:39-4.19, and for conducting and managing the pharmacy so as to be in compliance with all applicable state and federal laws.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Name of Pharmacy (give exact legal title)

Title

Print name

Authorized signature

Subscribed and sworn to me this _____
day of _____, 20_____

Name of Notary Public (please print)

Signature of Notary Public

Affix seal here

If more than two (2) parties are participating in this agreement, attach additional affidavits as needed.